



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TOMBALL REGIONAL HOSPITAL
PO BOX 889
TOMBALL TX 77377-0889

Respondent Name

TPS JOINT SELF INS FUNDS

Carrier's Austin Representative Box

Box Number 11

MFDR Tracking Number

M4-06-1187-01

MFDR Date Received

October 13, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "F&R reimbursement as recommended to the Commission by Ingenix in 2002 to develop MARs for hospital outpatient fee guidelines. A market reimbursement of 140% of Medicare's HOPPS would meet the statutory requirements of Section 413.011(d) 2004 HOPPS median payment for code 29806 is \$3,101.80 x 140% = MAR. Rev Code 274 is reimbursable at 110%."

Amount in Dispute: \$3,275.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent notes that the Requestor, in its supplemental material, reduces the amount-in-dispute from \$3,275.01 to \$698.51. Respondent is reconsidering its position in light of Requestor's position statement. Should Respondent alter its position, it will notify both the Division and the Requestor immediately."

Response Submitted by: Harris & Harris, 5300 Bee Cave Road, Building III, Suite 200, Austin, Texas 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2004	Outpatient Hospital Services	\$3,275.01	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

4. This request for medical fee dispute resolution was received by the Division on October 13, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 27, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration *Merit-The attached charges have been reimbursed to the medical provider in a fair, reasonable, & consistent methodology, pursuant to applicable laws in the treating providers jurisdiction.
 - M – Reduced to fair and reasonable *Reviewed by merit

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "F&R reimbursement as recommended to the Commission by Ingenix in 2002 to develop MARs for hospital outpatient fee guidelines. A market reimbursement of 140% of Medicare's HOPPS would meet the statutory requirements of Section 413.011(d) 2004 HOPPS median payment for code 29806 is \$3,101.80 x 140% = MAR. Rev Code 274 is reimbursable at 110%."
 - The requestor did not submit documentation to support that a market reimbursement of 140% of Medicare's HOPPS would meet the statutory requirements of Section 413.011(d).
 - The requestor does not discuss or explain how the reimbursement as recommended to the Commission by Ingenix in 2002 to develop MARs for hospital outpatient fee guidelines supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>December 14, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.